Form 142 Rev. 08/2001

STATE OF UTAH - LABOR COMMISSION
Division of Industrial Accidents
160 East 300 South, 3rd Floor, P. O. Box 146610
Salt Lake City, Utah 84114-6610
(801) 530-6800 Fax (801) 530-6804

STATEMENT OF INSURANCE CARRIER OR SELF-INSURER WITH RESPECT TO DISCONTINUANCE OF BENEFITS

(Employee notification of the discontinuance of weekly compensation benefits)

Rule R612-1-3(G) of the Labor Commission workers' compensation rules require that this form must be mailed to the employee and filed with the Labor Commission five (5) days before the date compensation stops for any reason.

Employee: _____ Date of Injury: _____

Address: _____ Phone:_____

_____ Social Security #: _____

Employer:

Insurance Carrier: _____ Date of Filing: _____

Adjustor: _____ Phone Number:_____

Date - Reasons for Suspension Effective:

___ Doctor has not filed supplemental reports.
___ Claimant moved and failed to inform carrier of new address.
___Claimant left State and changed doctors without permission.
___Claimant changed doctors without permission. ➔➔➔➔
___Claimant has failed to keep doctor appointment(s).
___Claimant refuses to be seen for independent evaluation.
___Other:_____
_____
_____

PER RULE 612-2-9. CHANGE OF DOCTORS AND HOSPITALS. The employee may make one change of doctor without requesting permission of the carrier, so long as the carrier is promptly notified . . . (refer to rule for complete text).

NOTICE TO THE APPLICANT: If you are in disagreement with the carrier and cannot resolve your differences by talking with the carrier and/or your treating physician, you should then call the Labor Commission, Division of Industrial Accidents, for further instructions. You may have additional benefits due, if you have sustained permanent loss of body function due to your industrial injury. Please check with your physician. If your physician has given you a permanent partial rating, the rating needs to be sent to the adjustor listed at the top of this form.

*** * * IF YOU BELIEVE THAT YOU ARE ENTITLED TO UNEMPLOYMENT BENEFITS AFTER THE SUSPENSION OF WORKERS' COMPENSATION BENEFITS, YOU MUST FILE WITHIN 90 DAYS OF THE DATE OF YOUR RELEASE TO RETURN TO WORK. * * ***

NOTICE TO INSURANCE CARRIER/EMPLOYER: This form is to be mailed to the doctor, if the doctor is involved in any way with suspension of temporary total disability compensation. Benefits should continue until 5 days after the mailing of this form to the Applicant and the Labor Commission.

***ADJUSTOR: If claimant has been released to return to work, Form 110 "Release to Return to Work" must be sent to the Labor Commission and the injured worker within five (5) calendar days of release for work.**